DOCUMENT RESUME

ED 393 571 PS 024 031

TITLE	A Nation's Shame: Fatal Child Abuse and Neglect in the United States. A Report of the U.S. Advisory Board on Child Abuse and Neglect. Fifth Report. Executive Summary.
INSTITUTION	United States Advisory Board on Child Abuse and Neglect, Washington, DC.
SPONS AGENCY	Administration for Children, Youth, and Families (DHHS), Washington, D.C.
PUB DATE	Apr 95
NOTE	45p.; For the full report summarized here, see PS 024 030.
PUB TYPE	Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Agency Cooperation; Change Strategies; *Child Abuse; Child Caregivers; Child Health; *Child Neglect; Child Welfare; Community Involvement; *Death; Family Programs; Homicide; Integrated Services; Investigations; Law Enforcement; Parents; *Prevention; Program Improvement; Social Problems; *Social Services; State Legislation; Training; *Young Children
IDENTIFIERS	Autopsies; Cause of Death; Child Abuse Prevention and Treatment Act; Child Safety; Family Preservation Services; Family Support

ABSTRACT

The U.S. Advisory Board on Child Abuse and Neglect was established under the Child Abuse Prevention and Treatment Act (CAPTA). In its annual reports, the Board is charged with evaluating the nation's efforts to accomplish the purpose of CAPTA and to propose recommendations about ways those efforts can be improved. Noting that every day, five young children die of abuse or neglect at the hands of their parents or caregivers, this Executive Summary provides highlights from the Board's report on existing efforts and opportunities that aid in understanding child abuse and neglect fatalities. The four chapters of the summary address: (1) the lack of knowledge over the scope and nature of child abuse and neglect fatalities; (2) the need for better investigation and prosecution and for major efforts to improve and train front-line professionals; (3) the encouraging emergence of Child Death Review Teams; and (4) the need for more aggressive efforts to protect children and facilitate community-based family services and primary prevention efforts to help families live safe and healthy lives. Also summarized are the Board's 26 recommendations for addressing problems in various arenas that constitute the child welfare system, including: (1) establishing an national commitment to addressing the problem of abuse and neglect fatalities; (2) increasing the number of professionals qualified to identify and investigate such fatalities; and (3) using family support funding for prevention. (HTH)

PS

U.S. DEPARTMENT
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A Nation's Shame: Fatal Child Abuse and Neglect in the United States

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Executive Summary

A Report of the U.S. Advisory Board on Child Abuse and Neglect

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Administration for Children and Families

A NATION'S SHAME: FATAL CHILD ABUSE AND NEGLECT IN THE UNITED STATES

A Report of the
U.S. Advisory Board on Child Abuse and Neglect

Executive Summary

Fifth Report
U.S. Advisory Board on Child Abuse and Neglect
April 1995

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Washington, DC

"A simple child,

That lightly draws its breath,

And feels its life in every limb,

What should it know of death?"

William Wordsworth

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DEDICATION

This report is dedicated to the children on the following list and the thousands not named here, who have died at the hands of parents or caretakers. The names are taken from newspaper articles published throughout the country.

Sources: New York Times, Chicago Tribune, Houston Post, Denver Post, San Francisco Chronicle, Los Angeles Times, Boston Globe, Atlanta Constitution-Journal, Philadelphia Inquirer, Miami Herald, Detroit Free Press, Washington Post.

Joann --6th Grade
Fair Avenue School

Name	*Age*	*Cause of Death*	*Date*	*Location*
Michael A. Lazas, Jr.	*2 years*	*Suffocation.*	*1/93*	*Maryland*
David Welch	*3 years*	*Severely beaten.*	*1/93*	*Florida*
Baby Boy Braz	*2 months*	*Manner unspecified.*	*1/93*	*California*
Francisco Lopaz	*2-1/2 years*	*Died from 103 body wounds.*	*1993*	*Illinois*
Unnamed	*Newborn*	*Buried alive.*	*2/16/93*	*New York*
Baby Rodriguez	*5 months Twin Girl*	*Severely beaten.*	*2/15/93*	*Texas*
Amy Lynn Mitich	*2 months*	*Suffocation.*	*2/25/93*	*Florida*
Jamiel Neal	*3 years*	*Severely battered and burned with a stun gun.*	*2/28/93*	*Michigan*
Baby Boy Jones	*Infant*	*Manner of death unspecified.*	*2/93*	*Colorado*
Samantha Jo Haight	*4 years*	*Severely beaten.*	*2/93*	*Illinois*
Tommy Eken	*3 months*	*Manner of death unspecified.*	*2/93*	*Illinois*
Ditaya Douglas	*2 years*	*Death by scalding.*	*3/20/93*	*New York*
Shayne Bryant	*4 years*	*Scalded and beaten.*	*3/93*	*New York*
Keeyan Pinnick	*1 year*	*Death by scalding.*	*4/2/93*	*Illinois*
Jose Manuel Garcia	*2 years*	*Burned to death.*	*4/2/93*	*Florida*
Lauren Jandree	*Toddler*	*Severely beaten.*	*4/3/93*	*Texas*
Saraphina Johnson	*5 months*	*Shaken to death.*	*4/93*	*Illinois*
Tiffany Guzman	*1 year*	*Smothered to end crying.*	*4/93*	*Texas*

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Name	*Age*	*Cause of Death*	*Date*	*Location*
Brittany Harris	*2 years*	*Manner of death unspecified.*	*4/93*	*Texas*
Devon Phillips	*5 years*	*Stabbed to death.*	*4/93*	*District of Columbia*
Thomas Owenby	*10 months*	*Starved to death.*	*4/93*	*District of Columbia*
Thomas McNeil	*10 months*	*Starved to death.*	*4/93*	*District of Columbia*
Joseph Wallace	*3 years*	*Forcibly hung by neck.*	*4/93*	*Illinois*
Donnell Robinson	*2 years*	*Fatally shaken.*	*5/4/93*	*Virginia*
Tish Phipps	*Toddler*	*Severely beaten.*	*5/8/93*	*Texas*
Ryan Plimpton	*6 months*	*Massive head injuries.*	*5/93*	*Illinois*
Ariel Hill	*5 months*	*Scalded to death.*	*5/12/93*	*Illinois*
Jasmine Kent	*2 years*	*Severely beaten.*	*5/21/93*	*Illinois*
A.J. Schwarz	*10 years*	*Found battered and floating in family pool.*	*5/23/93*	*Florida*
Donnell Shaw	*2 years*	*Massive head injuries.*	*5/26/93*	*Florida*
Brandon Jones	*9 months*	*Massive head injuries.*	*5/93*	*Florida*
Jermey Booze	*2-1/2 years*	*Massive head injuries.*	*5/93*	*Florida*
Robert Earl Jefferson	*2 years*	*Fatally shaken.*	*5/93*	*Florida*
Myowsha Holoman	*1 year*	*Severely beaten.*	*5/93*	*Illinois*
Lindsay Creason	*3 weeks old*	*Smothered to end crying.*	*6/93*	*Colorado*
Adrain Adam Bell	*3 years*	*Severely beaten.*	*7/93*	*District of Columbia*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Clayton Miracle	*3 years*	*Severely beaten by foster parents.*	*8/11/93*	*Georgia*
Robert Ward Spencer	*8 years*	*Severely beaten.*	*9/93*	*District of Columbia*
Cody James	*19 months*	*Forced Valium overdose.*	*1993*	*Colorado*
Tiarah Bowers	*2 years*	*Chronically battered to death.*	*7/93*	*Illinois*
Cimantha Shepeard	*10 days*	*Dropped two stories.*	*7/93*	*Illinois*
Latoya Harris	*8 years*	*Found entombed in cement.*	*7/93*	*California*
Jeremy Arans	*3 months*	*Massive head injuries.*	*8/4/93*	*Illinois*
Kevin Kreith	*3 years*	*Severely beaten.*	*8/93*	*Illinois*
Michael Cecil	*2 years*	*Chronically battered to death.*	*8/15/93*	*Illinois*
Saleem Broom	*1 year*	*Starved to death.*	*8/21/93*	*New York*
Denise Rome	*2 years*	*Manner of death unspecified.*	*9/2/93*	*Ohio*
Louis Murphy	*2 years*	*Severely beaten.*	*9/17/93*	*Texas*
Anonymous Toddler	*3 years*	*Severely beaten after crying over fear of dark.*	*9/93*	*California*
Corey Sparks	*2 years*	*Severely beaten.*	*10/93*	*Illinois*
Brittany Scott	*5 years*	*Massive head injuries.*	*10/93*	*Michigan*
Jonathan Boylan	*6 months*	*Massive head injuries and choked.*	*10/13/93*	*Florida*
Kayla Basante	*8 months*	*Choked with blanket.*	*11/93*	*Florida*
Cecilia Marie Rushing	*2 years*	*Fatally beaten.*	*11/93*	*District of Columbia*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Tommy Bush	*4 years*	*Severely beaten.*	*11/2/93*	*Florida*
Richard Spells	*4 months*	*Massive head injuries.*	*11/9/93*	*Illinois*
Kieran Dunne	*10 months*	*Severely beaten.*	*11/9/93 or 11/10/93*	*New York*
Tonya Heddins	*2 months*	*Forcibly suffocated following chronic abuse.*	*11/10/93*	*Illinois*
Baby Girl Glover	*5 months*	*Severely beaten.*	*1993*	*Colorado*
Shawna Reeder	*15 months*	*Manner of death unspecified.*	*11/93*	*New York*
Latisha Lawrence	*15 months*	*Manner of death unspecified.*	*11/93*	*New York*
Baby Girl Casares	*Infant*	*Manner of death unspecified.*	*12/3/93*	*California*
Unidentified girl	*17 months*	*Beaten all over body.*	*12/24/93*	*Florida*
Richard Jones	*1-1/2 years*	*Severe intoxication.*	*12/25/93*	*Connecticut*
Michael Marshall III	*Infant*	*Severely beaten.*	*12/93*	*Illinois*
Joseph M. Harvey	*3 years*	*Fatally scalded in bathtub.*	*12/93*	*Maryland*
Christopher Flye	*6 years*	*Severely abused.*	*1993*	*Maryland*
Danny Carter, Jr.	*2 years*	*Severely beaten after bedwetting.*	*1993*	*Virginia*
TeSean J. Bond	*2 months*	*Force fed fatal amounts of Epsom salts and liquid antacids.*	*1994*	*District of Columbia*
Roosevelt Bryan Bell	*5 months*	*Fatally shaken.*	*1/1/94*	*Illinois*
Baby Girl Buchanan	*3 months*	*Starved to death.*	*1/94*	*Illinois*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Baby Williams	*2 years*	*Fatally scalded.*	*1/13/94*	*Texas*
Kelly Jackson	*4 months*	*Fatally shaken.*	*1/20/94*	*Illinois*
Jimmie Williams	*2 years*	*Severely beaten after bedwetting.*	*1994*	*Illinois*
Erick Stark	*16 months*	*Chronically battered.*	*1994*	*Illinois*
Jackie Wright	*7 years*	*Bludgeoned to death.*	*2/94*	*Maryland*
Tenicha Nixon	*8 months*	*Severely battered for crying.*	*3/22/94*	*Florida*
Carol Jean Waters	*Toddler*	*Fatally beaten.*	*3/26/94*	*Florida*
Jasmine Buice	*1-1/2 years*	*Severely beaten.*	*3/9/94*	*Texas*
Jodi Santillo	*3 years*	*Massive head injuries.*	*4/7/94*	*Florida*
Baby girl Wright	*2 years*	*Bitten and severely beaten.*	*4/14/94*	*Florida*
Daryl Bell, Jr.	*2 years*	*Severely beaten after wetting pants.*	*4/94*	*Illinois*
Andre Roberts	*1 yea*	*Severely beaten.*	*4/94*	*Illinois*
Tyesha Dixon	*1 year*	*Starved and beaten.*	*4/2/94*	*Texas*
Raychell Ortiz	*4 years*	*Killed and tossed in river.*	*5/4/94*	*New York*
Unidentified	*3 years*	*Beaten with towel rack.*	*5/29/94*	*Florida*
Michael Scott Richman	*1 month*	*Massive head injuries.*	*5/30/94*	*Florida*
Corey D. Taylor	*3 years*	*Pushed into Anacostia River and drowned.*	*5/94*	*District of Columbia*
Charles Sanborn	*10 years*	*Chronically battered.*	*6/94*	*Illinois*
Baby boy Day	*Toddler*	*Manner of death unspecified.*	*6/2/94*	*Florida*
Baby Boy Adams	*14 months*	*Scalded and beaten.*	*6/18/94*	*California*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Anaberta James	*8 months*	*Manner of death unspecified.*	*6/19/94*	*Texas*
Eric Dunphy	*2 years*	*Severely beaten and stuffed into a Christmas ornament box.*	*8/94*	*Rhode Island*
Christina Holt	*7 years*	*Beaten to death.*	*9/94*	*Florida*
Dayton Boyton	*5 months*	*Injuries unspecified.*	*10/94*	*Florida*
Damian Grant	*2 years*	*Fatally beaten.*	*10/21/94*	*Florida*
Sasha Gibbons	*4 years*	*Suffocated.*	*11/23/94*	*Florida*
Unidentified baby girl	*?*	*Head injuries from being tossed in air.*	*12/1/94*	*Florida*
Rafael Jose	*8 years*	*Stabbed in heart.*	*12/10/94*	*Florida*
Anthony Dorch	*1-1/2 months*	*Severely battered.*	*12/13/94*	*Florida*
Tiffany Greenfield	*4 months*	*Fatally shaken.*	*12/21/94*	*Florida*
Joey Fajardo	*3 weeks*	*Fatally shaken.*	*12/24/94*	*Florida*
Baby boy Thorpe	*4 months*	*Found in plastic bag in vacant lot.*	*1/95*	*Florida*
Jonathan Austin	*5 weeks*	*Fatally beaten.*	*1/8/95*	*Pennsylvania*
Felicia Brown	*1-1/2 years*	*Beaten with shoe heel.*	*2/95*	*Michigan*

FOREWORD

by Deanne Tilton Durfee

Chairperson, U.S. Advisory Board on Child Abuse and Neglect

OUR CHALLENGE

The U.S. Advisory Board on Child Abuse and Neglect began the daunting task of confronting the most extreme and tragic consequences of child maltreatment over 2 years ago. This has clearly been the most challenging and the most comprehensive process this Board has yet undertaken. Our study, discussions, review of material, and testimony from multiple States have revealed a problem far greater than previously realized. We also have been the beneficiaries of far greater insight into the strengths and weaknesses of the broader community-and government-based child protection systems.

The cruel realization that parents and caretakers can kill their own children has been difficult for our Nation to face. Indeed, many who make policies, direct programs, and deliver services to children and families have found it difficult to accept. Yet, this is reality.

For so many who question the importance of providing preventive services to high risk families, especially those with small children, let this report serve as a reminder of what the tragic outcome of indifference may be. For those who believe that the child protection system is overly intrusive, let us recall how we might have wished there had been a meaningful intervention before the death of a helpless young victim. Let us also ask how a strong community support system—friends, family, neighbors—could have helped assure the safety of a preschool child who was never seen outside the home until autopsy.

Serving as a member of the U.S. Advisory Board on Child Abuse and Neglect has been a consuming experience. This report, which has required confronting the unnecessary loss of helpless children's lives, has profoundly drawn on the personal and psychological energies of Board members and staff. Yet, by reviewing child deaths, we have been able to expand our appreciation and understanding of the importance of children's lives.

The future work of this Board will benefit greatly from the wealth of information gained through this process. The issues related to child abuse fatalities—accountability, professional qualifications, interagency collaboration, information sharing, and prevention—all sit at the foundation of our entire child protection system.

The Board heard the perspectives of true heroes; professionals, volunteers, and concerned citizens from diverse communities across the Nation. These are some of the most brilliant, dedicated, and insightful individuals we could have the privilege to meet.

We have been motivated by a belief that the purpose of life is to matter, to count, to have it make some difference that we lived at all. Having experienced the pain of children, we seek to honor them and confirm that their brief lives did matter, each and every one of them. By better understanding child abuse and neglect fatalities, and how such tragedies could be prevented, we are given a great opportunity to ensure that it did make a difference that these children lived at all.

ACKNOWLEDGMENTS

The Board members, staff, and others involved in the development of this report have invested their hearts, minds, time and energy to making a difference in the lives of children and families in America.

It has been a profound honor to serve as Chair of this prestigious Board for the past 2 years. I came into this position following in the footsteps of two of the most highly respected professionals in this field, **Richard Krugman** and **Howard Davidson**, our Board's first two Chairs. We all owe much to their leadership and the standards and direction they set for our work. Other previous members of the Board who participated in the initial stages of the development of this report also deserve recognition. They should feel justifiable credit for their role in laying the groundwork for this report.

Special recognition must be given to the Vice-Chair of the Board **Yvonne Chase**, who provided direction, advice, and leadership in all aspects of the Board's work. She also provided me with invaluable personal support. During the process of developing this report on child maltreatment fatalities, Yvonne took leadership in organizing meetings, symposia, and hearings on cultural diversity in partnership with the People of Color Leadership Institute (POCLI). These forums produced unique and enlightening dialogue and constitute an important foundation for future Board reports.

All members of the Board deserve credit for their dedication to protecting children and serving families and for their important contributions to this report. Special recognition was earned by the members of the Board's Executive Committee, **Randy Alexander, Jane Burnley, J. Tom Morgan, and Michael Weber,** for their additional investment of time and energy. This included frequent conference calls, special meetings, repeated editing, and responsibility for developing sections of the draft report. **Enid Borden,** former member of the Executive Committee, continued to share her considerable creativity with the written word, and **Murray Levine** brought us a wealth of talent in research and evaluation.

The Executive Director of the Board, **Preston Bruce,** has been our ambassador, our source of moral support, and one of the kindest and most caring individuals I have had the pleasure to know. Preston brings a strong heritage of distinguished public service to his work. Sadly, Preston's father passed away only a few months before this report could be completed. There is no doubt he would have been very proud of his son.

Our Board met with tremendous good fortune when we contracted with **Laurel Consulting Group,** a professional management services firm that exceeded all of our expectations for both quality and quantity of work. We owe special thanks to **Conrad Kenley**, President of LCG, whose mind and management skills are unparalleled, and to **Anne Marie Finn,** policy analyst, whose intelligence, good nature, and ability to absorb and translate masses of information proved invaluable. Conrad and Anne Marie, joined by other outstanding LCG staff, worked into nights and weekends to assure that this report was of high quality and completed on time.

Jill Stewart a widely respected newspaper and magazine writer, provided our Board with the gift of her notable journalistic talent. She was the individual who brought together the masses of information presented to us from,testimony; local State, and Federal reports; journal articles, news reports and literally thousands of pages of transcripts from hearings, symposia, and meetings. Her organization, creative mind, writing skills, and a deep personal concern for the children about whom she was writing made her an invaluable member of our "team."

Penny Weiss, ICAN Assistant Director, and **Mitch Mason,** ICAN Program Analyst, deserve a great deal of credit for lending their considerable talents to many aspects of this report, and for their patience with me during my term as Chairperson.

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Finally, I most sincerely thank **Michael Durfee,** my hero and best friend. He has provided me with unrelenting encouragement and moral support, even when I have found myself tired and rather intolerable. Moreover, he is more responsible than anyone I know for moving this country toward a better system of accountability for the serious and fatal abuse of children.

The Board also wishes to acknowledge the important contributions of the following individuals and organizations in the development of this report:

- Jose Alfaro, Director of Research, Children's Aid Society and Donya Witherspoon, Attorney at Law for lending their expertise to the task of summarizing expert testimony taken by the Board in New York City and Los Angeles.

- Sharon Smolick Director of Family Violence Program, Bedford Hills Correctional Facility for her cooperation in allowing Board members access to the women who shared their stories with us.

- Cheryl Compaan and Jennifer Freeman at the State University of New York for additional bibliographic research.

- All of the Department of Health and Human Services Regional staff for their logistical support and input in public hearings and forums.

- and, finally, the Board would like to thank Cathie O'Donnell from Circle Solutions Inc. for editing this report.

MISSION AND COMPOSITION OF THE U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

The U.S. Advisory Board on Child Abuse and Neglect was established under 100-294, Section 102, of the Child Abuse Prevention and Treatment Act (CAPTA), amendments of 1988. It consists of 15 members appointed by the Secretary of Health and Human Services (DHHS). Members represent a wide range of legislatively mandated disciplines, as well as various regions of the country and diverse personal perspectives. The name, title, and address of each Board member are listed in Appendix A.

Explicit provisions of CAPTA require the Board to prepare an annual report to the Secretary of DHHS, appropriate committees of Congress, and the Director of the National Center on Child Abuse and Neglect (NCCAN). In its reports, the Board is charged with evaluating the Nation's efforts to accomplish the purpose of CAPTA and to propose recommendations about ways those efforts can be improved.

In its first report in 1990, the Board concluded that the problem of child maltreatment in the United States had escalated to the level of a national emergency based on the alarming increase in the number of abuse and neglect reports and the negative consequences for society, especially for children. It recommended 31 critical steps to address this national emergency, directed to all levels of government, all professional disciplines and each citizen. One recommendation called for an effort to bring agencies together at local, State, and Federal levels to address fatal child abuse and neglect.

In its second report in 1991, the Board urged funding, structural reforms, and action at the Federal level to bring critically needed preventive services to communities. Key among its recommendations was the implementation of universal voluntary neonatal home visiting programs as a means of early prevention of abuse and neglect. The third report, in 1992, was devoted largely to recording Board activities and positions issued that year.

Building on the community-based preventive philosophy of its 1991 report, in 1993 the Board described the steps that must be taken to create a comprehensive new neighborhood-based prevention strategy in which government, front-line professionals, neighbors, families, and friends all play a role.

This report reflects a response to the Board's longstanding concern for children who die at the hands of their parents or caretakers. Members of Congress shared this concern, and in 1992 congressional hearings were held, resulting in a mandate to the Board to issue a report on the nature and extent of child abuse and neglect fatalities and how these tragic deaths might be prevented.

EXECUTIVE SUMMARY

Background

In 1991, a riveting PBS documentary told the story of the brutal death of malnourished 5-year-old Adam Mann, beaten to death on March 3, 1990, by his stepfather, Rufus Chisolm, with participation by his mother, Michelle Mann (Langer, 1991). Many professionals had missed a series of red flags that Adam was in serious danger. The autopsy of Adam revealed over 100 injuries on his body. Following the autopsy, the cause of death was listed as a broken skull, broken ribs, and a split liver. At one time or another, nearly every bone in his body had been broken. In addition, there was no food in his stomach. Adam's stepfather and mother were imprisoned and Adam's siblings were placed in foster care. The story of this child's death, as well as compelling testimony regarding hundreds of child abuse fatalities, prompted Congress to ask the U.S. Advisory Board on Child Abuse and Neglect (ABCAN) to recommend:

2,000 children die from abuse or neglect each year...or 5 children every day.

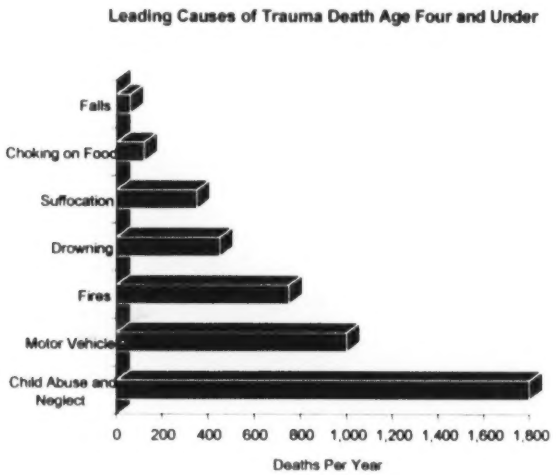
- a national policy to reduce and ultimately prevent such fatalities,
- changes to achieve an effective Federal role on the implementation of the policy, and
- changes needed to improve data collection about child abuse and neglect fatalities.

Since Adam's death, some 10,000 children have died at the hands of their parents or caretakers.

Conservative estimates indicate that almost 2,000 infants and young children die from abuse or neglect by parents or caretakers each year, or *5 children every day.* The vast majority are under 4 years old,

Homicide rates among children age 4 and under have hit a 40-year high.

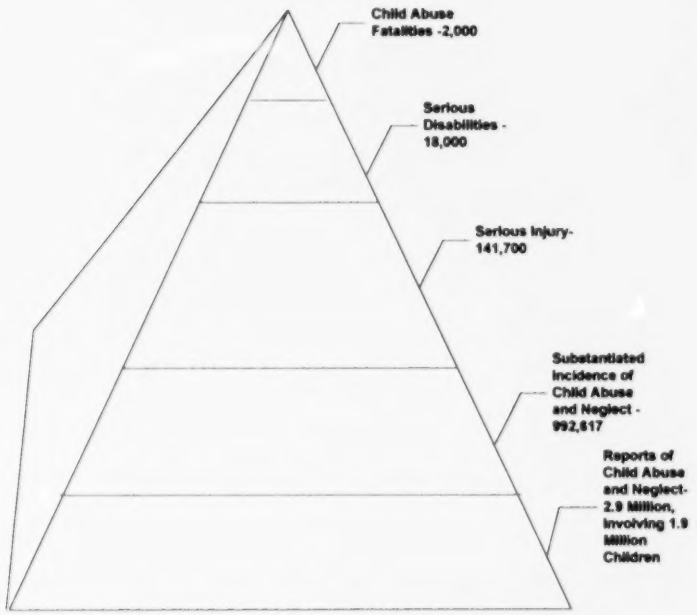
an age when they are most vulnerable to physical attacks and to dangers created by lack of supervision and severe neglect, and are isolated from teachers or others who might intervene to protect them. According to the Population Reference Bureau, death rates among children age 4 and under who die from homicide have hit a 40-year high (Mackellar & Yanagishita, 1995; *Baltimore Sun*, 1995). Violence towards very young children has reached the level of a public health crisis and is similar in scope to the destruction of teenagers by street gunfire.



Source National Safety Council Child Abuse and Neglect deaths from Centers for Disease Control and Prevention

Yet the American public, as well as many government leaders and policymakers at the local, State, and Federal levels continue to regard these deaths as if they are rare and tragic curiosities. We hope to dispel this notion, which we believe impedes any meaningful solution. McClain's research at the Centers for Disease Control and

Prevention (CDC) suggests that abuse and neglect kills 5.4 out of every 100,000 children age 4 and under (McClain et al, 1993; McClain, 1995). However, due to the misclassification of child deaths, McClain believes that a second conservative estimate can be as high as 11.6 per 100,000 children age 4 and under (McClain, 1995). This is a shocking rate compared with deaths among teenagers from gunshot wounds and deaths among children age 15 and under from auto accidents—neither of which are downplayed as "rare" events. As shown, abuse and neglect has become one of the biggest threats to the lives of infants and small children in America. Deaths from abuse and neglect of children age 4 and under outnumber those from falls, choking on food, suffocation, drowning, residential fires, and motor vehicle accidents.


Child Abuse Fatalities -2,000
Serious Disabilities - 18,000
Serious Injury- 141,700
Substantiated Incidence of Child Abuse and Neglect - 992,617
Reports of Child Abuse and Neglect- 2.9 Million, Involving 1.9 Million Children

Sources: U.S. Advisory Board on Child Abuse and Neglect; Baladerian, Verbal testimony, 1994; NCCAN, 1991; National Committee to Prevent Child Abuse

It is particularly difficult to accept the alarming levels of abuse and neglect deaths in the 1990's, given that death rates among infants and young children from all other major causes are steadily declining.

Yet fatalities are not the entire story. The misery caused by near-fatal abuse and neglect ripples through this country, each year leaving 18,000 permanently disabled children (Baladerian, 1991), tens of thousands of victims overwhelmed by lifelong psychological trauma, thousands of traumatized siblings and family members, and thousands of near-death survivors who, as adults, continue to bear the

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physical and psychological scars. Some may turn to crime or domestic violence or become abusers themselves.

Near-fatal injury is nearly as appalling in its destruction as the toll of dead children. Many children with head injuries known to be caused by abusive caretakers are left with lifelong cerebral palsy (Diamond & Jaudes, 1983). The National Center on Child Abuse and Neglect (NCCAN) estimates that 141,700 infants and children were seriously injured due to abuse or neglect in 1990 alone (1991). The National Research Council (NRC) points out that, beyond these human costs, "the future lost productivity of severely abused children is $658 million to $1.3. billion, if their impairments limit their potential earnings by only five to ten percent" (NRC, 1993, p. 40).

...141,700 infants and children were seriously injured due to abuse or neglect in 1990 alone.

Each year we learn more about which children have died and which parents and caretakers are responsible. We know that a disproportionate number of victims come from low-income families with multiple problems. However, children of middle-and-high income families also die at the hands of their parents or caretakers. Such was the case of Lisa Steinberg who died in 1987 under the care of Joel Steinberg and Hedda Nussbaum, an upper middle-class white couple. In addition, research suggests that males cause most physical abuse fatalities, and that mothers are held responsible for most deaths caused by severe neglect. Furthermore, abuse and neglect deaths are not limited to inner cities. Such deaths occur in many communities, including isolated rural areas.

What we must ask is why. Must 2,000 babies and small children die at the hands of their parents or caretakers in 1995? What events lead up to these tragic deaths? What goes on in the minds of parents or caretakers that cause them to abandon their protective roles and lash out at or severely neglect tiny, helpless children? Angry

Americans asked this question of Rufus Chisolm and Michelle Mann, as well as Joel Steinberg, who beat their children to death. But these are questions that cannot be answered—or addressed—until this Nation chooses to tackle this long-ignored crisis in a meaningful way.

How Can We Address This Devastating Crisis?

This report offers a discussion of the existing efforts and opportunities that show promise in helping us to understand and prevent child abuse and neglect fatalities. These efforts emerge from motivated individuals and agencies that have assumed strong leadership roles in the response to and prevention of child abuse and neglect fatalities. In addition, many communities have established neighborhood support systems to prevent child abuse and neglect.

This report also provides a close look at systemwide weaknesses and obstacles, and a lack of resources and commitment by policymakers to take action that could save children's lives. Thus, we wish to send a wake-up call to those who may minimize this crisis and to those who do not know this crisis exists.

We offer 26 Recommendations for addressing deep-seated problems within the law enforcement, child protection and health agencies and courts that comprise the country's child protection system. Our recommendations are addressed to Congress, sStates, public policymakers, and all citizens.

The four chapters of the report address: (1.) the lack of knowledge over the scope and nature of child abuse and neglect fatalities, (2.) the need for better investigation and prosecution and for major efforts to improve and train front-line professionals, (3.) the encouraging emergence of Child Death Review Teams, (4.) the need for more aggressive efforts to protect children and facilitate

community-based family services and primary prevention efforts to help families live safe and healthy lives.

Chapter One: Quantifying the Problem

Our society has, in this century, kept a watchful eye on virtually every cause of child death, using what we have learned to quantify the scope and nature of threats to children's health and safety and then to design prevention efforts. These efforts have included the war on polio and, more recently, the massive investment in automobile safety seats for children younger than age 4. But when it comes to deaths of infants and small children due to physical abuse or severe neglect, few resources have been expended to understand this phenomenon. Its scope and very nature remain essentially unknown.

...85 percent of childhood deaths from abuse and neglect are systematically misidentified.

It has been estimated that 85 percent of childhood deaths from abuse and neglect are systematically misidentified as accidental, disease related, or due to other causes (NRC, 1993; McClain et al, 1993; Ewigman et al, 1993). This arises from poor medical diagnoses, incomplete investigations, and widespread flaws in the way deaths are recorded on death certificates, in crime reports, and by the child protection system.

"The germ theory of disease is at least a century old, and I often say that we're at about the year 1930 in terms of our understanding of child maltreatment. We are still arguing about whether a case is maltreatment or not, just as we once argued, is this an infectious disease or not?—Dr. Bernard Ewigman, University of Missouri, Department of Medicine, New York Focus groups, 1994

As a result of this misclassification and misdiagnosis, we do not have a reliable source to determine accurately why or exactly how many children die from abuse and neglect. Each national information system is incomplete as a source of comprehensive information on child abuse and neglect deaths. Vital Statistics, the FBI's Uniform Crime Reports, and State child abuse indices each track just one limited part of the picture.

In Chapter One, our Recommendations address this widespread lack of knowledge that badly hampers our ability to prevent fatal child abuse and neglect. Significantly reducing fatal child abuse and neglect and the attendant broad social, economic, and personal costs of severe abuse and neglect among survivors requires the highest level of attention, a far more sophisticated understanding of the problem, and a much greater commitment of our resources.

Chapter Two: Government and Individual Responsibility

The systems created in the United States to ensure that adult homicides are thoroughly investigated were never developed for children who die due to abuse and neglect by parents or caretakers. In times past, children were often seen as property. Many police, prosecutors, and judges viewed such deaths as a strictly social problem, not a criminal issue. Today, systemic failures created by those attitudes linger on. The question of who harmed a child is often never asked or answered, and in too many cases perpetrators have gone undetected to harm or kill other children.

Even if a fatality is recognized by the system and an investigation is launched, the criminal justice system may respond poorly. Prosecutors often reduce child homicides, including those of a heinous nature, to lesser crimes or do not charge perpetrators at all. Prosecutors are hampered in part by murder statutes that do not fit many child fatalities. Cases are difficult to prove in court because most prosecutors have little training in child abuse and neglect, insufficient evidence is gathered, and autopsies are rarely performed by medical examiners with sufficient pediatric expertise. These problems in prosecuting cases are exacerbated by the fact that

These problems in prosecuting cases are exacerbated by the fact that witnesses are rare because most deaths occur in the privacy of the home...

witnesses are rare because most deaths occur in the privacy of the home, and some jury members cannot believe that any parent or caretaker would commit such acts upon a child.

Many of the key agencies involved still do not fully exercise their roles in investigating abuse and neglect or in assuring a child's safety. For example, a coroner may label a case of inflicted suffocation as "Sudden Infant Death Syndrome" to protect a family's reputation. The breakdown can be seen in the numbers of mandated reporters who do not alert child protective service (CPS) agencies when they recognize a child as abused or neglected. Zellman & Anther (1990) found that 22 percent of mandated reporters, including pediatricians, school principals, therapists, and day care operators, do not report suspected cases of abuse. They cited a lack of hard evidence of abuse and neglect—which is not required to make a report—and their belief that "I can do better than the system." They are often breaking State law.

Such practices among those who could be saving children's lives are extremely significant when one considers how many children die before their families are reported to a CPS agency. Over half the children who die from abuse and neglect nationwide are from families who have never been investigated by CPS. Yet, thousands of children who died in the past decade were known to at least one professional or agency that might have intervened to save their lives.

Over half the children who die are from families who have never been investigated by CPS.

The lack of specialized training among those who deal with high-risk families is the single biggest impediment to improving the system in two critical areas: saving children by recognizing life-threatening abuse or neglect and establishing how and why a child has died. It is clear that most police, medical examiners, health practitioners, and CPS workers do not have the level of expertise

needed to protect children from serious child abuse and neglect. We believe a concerted new training effort is needed.

States have struggled to address problems within the judicial system, noncompliance by mandated reporters, and systemwide training inadequacies. In the face of such basic, deep-rooted problems, it is not hard to see why the system appears to be in disarray when yet another tragic death of a child is made public in the media. We believe it is time for physicians, hospitals, police, prosecutors, teachers, therapists, the clergy, and communities at large to become active participants in a comprehensive child protection system and to bear greater responsibility for the safety of children.

In Chapter Two, our Recommendations further our philosophy of better educating professionals to identify and investigate abuse and neglect and to hold perpetrators responsible for child deaths.

Chapter Three: The Need For Child Death Review Teams

Our understanding of fatal child abuse and neglect is hampered by a vast societal lack of awareness combined with avoidance of the issue. In the 33 years since Dr. C. Henry Kempe first described the Battered Child Syndrome, more children have died from child abuse and neglect than from urban gang wars, AIDS, polio, or measles; yet the contrast in public attention and commitment of resources is vast.

An encouraging new development is the emergence of multiagency/multidisciplinary Child Death Review Teams, a phenomenon still so new and evolving that the very existence of the teams is not yet widely known to the public or national media. Already, Child Death Review Teams have become one of our richest

sources for understanding this quiet crisis. On a regular basis, teams must grapple with systemwide flaws and outmoded policies that often work to prevent authorities from recognizing and properly responding to deaths due to abuse and neglect. Experts from multiple agencies and disciplines serve as members of the teams. These teams review cases of child deaths and facilitate appropriate follow up. Such followup includes assuring that services are provided to surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems. In addition, teams can assist in identifying weaknesses in the child protection system and determining avenues for prevention efforts and improved training of front-line workers.

State-level teams may review individual cases, or in larger States, provide support and accountability for local teams. Well-designed, properly organized Child Death Review Teams appear to offer the greatest hope of defining the underlying nature and scope of fatalities due to child abuse and neglect.

Child Death Review Teams appear to offer the greatest hope of defining the underlying nature and scope of fatalities from child abuse and neglect.

In Chapter Three, our Recommendations emphasize the critical importance of Child Death Review Teams in assessing child fatalities, pinpointing system flaws, and promoting prevention services. Diverting even a small fraction of our national attention and resources to an integrated and comprehensive approach to the defense of children's lives is a monumental task that should begin with the broad use of Child Death Review Teams.

Chapter Four: Toward a Better Future

Part One: Family Services, Intervention, and Family Preservation

Child welfare and law enforcement agencies have an explicit statutory mandate to intervene to protect children when the family does not provide that protection. However, if the system is going to save children, this responsibility must be greatly broadened and seen as a collaboration among law enforcement, social service, public health, and education systems. The final critical component to this broader system must be neighbors, extended family, friends, and local agencies in every community. The child's safety and well-being must be a priority in all child and family programs.

Hundreds of thousands of families in which child abuse or neglect is confirmed do not even receive basic services.

Unfortunately, in many States, laws and policies regarding child protection and case management are inadequate or conflicting. The roles of all child protection agencies, especially with regard to emergency measures and followup investigations with parents, may be poorly defined. Moreover, most citizens do not feel a sense of responsibility for protecting the children in their neighborhoods.

Hundreds of thousands of families in which child abuse or neglect is confirmed do not even receive basic services to ameliorate the negative effects of such maltreatment (McCurdy & Daro, 1992). The cases are merely monitored and closed. In addition, decisions by front-line workers are often not responsive to a family's needs. These decisions are affected by limited funds and restrictive eligibility requirements.

The recent legislation creating the 5-year, $1 billion Family Preservation and Family Support Program has given States and counties a tremendous opportunity to shift from this crisis-driven

response system toward one that reduces the core family problems that we believe lead to abuse and neglect fatalities.

It is the strong belief of this Board that this legislation should serve as a catalyst for the growth of an integrated, prevention-oriented, community-based system of support for families and children.

Part Two: Fatality Prevention

There is probably no greater area of public debate in the child welfare field than the issue of how society should prevent fatalities at the hands of parents and caretakers. Invariably, when the death of a small child is reported in the media, well-meaning journalists and policymakers blame the CPS worker who appeared to know a child was living under dangerous conditions and yet failed to rescue that child.

We, as a society, want swift action and clear-cut policies. We condemn what appears to be the failure of the system and the "passing of the buck." However, this Board is convinced that the public debate over who "made a mistake" that led to a child's death focuses on the wrong issues. The best chance we have for reducing these deaths is by beginning to ask the right questions and focusing on the right issues. The media can play a key role in sending accurate and influential messages that could reduce serious and fatal child abuse and neglect not only to parents, but to all citizens.

The media can play a key role in sending accurate and influential messages.

The truth is that, except in obvious cases of imminent danger, no single agency or individual in the multiagency system of child protection workers, police, physicians, and courts has the ability to foresee serious abuse or neglect that can cause a child's death. In many ways, we are as ignorant about abuse and neglect fatalities today as we were about child sexual abuse in the 1970's. Many thousands of

infants and small children today live in what the literature refers to as "high-risk" families. In 1993, 500,00 to 650,000 parents and children were living in the streets either temporarily or permanently (personal communication, Debbie Chang, National Alliance to End Homelessness); 3.3 to 10 million households with children contained a violent male with a history of domestic abuse (Schecter & Edleson, 1994); and 11 million parents with children were abusing drugs and alcohol (personal communication, Narconon, U.S. Drug Education Division). Each of these factors is considered a risk factor for child abuse and neglect.

The minimal research conducted in this area has not identified specific behaviors that can single out parents whose action or inaction might end a child's life. Currently, the best predictor of future abuse is a pattern of past abuse.

Currently, the best predictor of future abuse is a pattern of past abuse.

This Board is urging Congress, the States, and policymakers to greatly improve the existing primary prevention efforts. In providing a comprehensive, early safety net for all children, we hope to influence the lives of many families, and thus identify and protect those unknown innocents who need our help the most.

Our design for primary prevention stresses child and family well-being in a healthier, more active, community-based setting. We are building upon our 1991 and 1993 Board reports, which urged the creation of a neighborhood-based, community system to serve families and the inclusion of neighbors, family, and friends in assuring the safety and well-being of children. This should include informal family and neighborhood support, assistance with difficult parenting issues via community-based programs, and crisis intervention services. It is our belief that, given such support, more parents and caretakers will

welcome a helping hand when it is needed and will raise their children in safety.

However, this Board also recognizes that some parents and caretakers, even with supportive services, cannot provide a safe home environment for their children. Therefore, it is imperative that, when necessary, a child's safety and well-being must be protected through prompt removal from the home and by expedited termination of parental rights (TPR) actions by the juvenile courts. We strongly believe that any child who suffers abuse or lives in a severely abusive family deserves permanent placement with a family who is willing to nurture and care for that child.

In Chapter Four, we pinpoint the populations at greatest risk for becoming victims of fatal abuse and neglect—very young children—as well as those at greatest risk for becoming perpetrators—male caretakers and parents of toddlers and infants. This Board emphasizes the great need for public awareness campaigns. In addition, we urge that when a family completely fails a child, the child be given a second chance with a new life and a new family in an expeditious manner.

Conclusion: The Challenge

ABCAN hopes that this report will awaken America to the national shame of child maltreatment-related fatalities and will galvanize all Americans to act now to prevent these tragedies.

SUMMARIZED RECOMMENDATIONS
OF THE
U. S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

Recommendation 1: Our Nation must establish a national commitment at the highest levels to understand the scope and nature of fatal child abuse and neglect.

We urge the U.S. Attorney General and the Secretary of Health and Human Services to devote existing resources and expertise to address the lack of knowledge regarding the true nature and extent of fatal child abuse and neglect in America.

Recommendation 2: Federal and State agencies must significantly increase research efforts on serious and fatal child abuse and neglect.

Research is needed to address the serious gaps in information on issues such as the effects of poverty, race, domestic violence, and substance abuse in serious and fatal child abuse and neglect, as well as the effectiveness of current services in preventing serious and fatal injury.

Recommendation 3: The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

The leadership of the Department of Health and Human Services and the Department of Justice should work with professional associations to develop a national strategy to address the dramatic lack of medical, law enforcement, legal and social service professionals qualified to identify and investigate child abuse and neglect fatalities.

Recommendation 4: There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.

The Secretary of Health and Human Services and the U.S. Attorney General should utilize funds to improve multidisciplinary training in all disciplines charged with identifying and investigating

child abuse and neglect fatalities, with an emphasis on crosstraining where possible. This effort should be tailored to a broad audience including child welfare workers, law enforcement officers, prosecutors, mental health practitioners, physicians, paramedics, emergency medical technicians, and others who might work in a front-line capacity.

Recommendation 5: States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

All States should create criminal investigation teams either at the local or regional level to investigate any "unexpected child death." Each team should include, at a minimum, a medical examiner, law enforcement officer, CPS worker and prosecutor. These teams should investigate all unexpected child deaths. Military branches and Indian Nations should work with Federal and State law enforcement and health authorities to establish such teams.

Recommendation 6: States and the Joint Commission on Accreditation of Health Care Organizations should adopt requirements to assure that all hospitals with pediatric services have Suspected Child Abuse and Neglect (SCAN) teams.

Any hospital with a pediatric unit should be required by the State, military branch, or Indian Nation, which oversees its certification, to have a SCAN team. SCAN teams should include a physician, social worker, and nurse specially trained to recognize, treat, report, and consult on suspected child abuse and neglect cases.

Recommendation 7: All states should enact legislation establishing child autopsy protocols. Federal funding for autopsies of children who die unexpectedly should be available under Medicaid.

Autopsies should be required at a minimum when any child's death is suspected as being a homicide or suicide, the child was not under supervision of medical personnel at time of death, or the cause of death is not readily determinable.

Recommendation 8: States should take steps to ensure that all children have access to available, necessary medical care when they are at risk of serious injury or death.

All states should ensure that child abuse laws include the provision that parents must provide medical care when such care is available and necessary to protect the child from death or serious harm. Failure to do so is reportable under child abuse and neglect reporting law.

States should ensure that all health care providers, including spiritual healers who receive healthcare reimbursement, are listed as mandatory reporters of child abuse and neglect, thereby involving such providers in training activities that are conducted for mandatory reporters.

Recommendation 9: States should enact "felony murder or homicide by child abuse" statutes for child abuse and neglect. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

Felony murder or homicide by child abuse and neglect statutes in all States should specifically include child abuse or neglect as one of the underlying felonies, as currently is the case in 21 States.

Recommendation 10: The Secretary of Health and Human Services and the U. S. Attorney General should work together to assure there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing process to support the national system of local, State, and Federal child abuse and neglect fatality review efforts.

A national structure is needed to incorporate the knowledge of the teams, establish a mechanism for disseminating that knowledge, and facilitate development of a national perspective to prevent child abuse and neglect fatalities. This can be accomplished through the designation of individuals within the Department of Health and Human Services and the Department of Justice who would assume ongoing responsibility to support the process and the semi-annual convening of experts from throughout the country to review and analyze relevant data, share information, track national trends, and develop recommendations.

Recommendation 11: A national-level effort should ensure that services and training materials on fatal child abuse and neglect are made available to all states.

Federal resources must be allocated to provide a far more meaningful level of expertise, technical assistance, and resources to professionals and agencies who need it. The Secretary of Health and Human Services and the Attorney General should oversee this interdisciplinary effort.

Recommendation 12: All States should have State-level Child Death Review Teams. Such teams should also be established within the military branches, Indian Nations and territories,

These multidisciplinary/multiagency child death review teams should include participation from criminal justice, health, social services, and other relevant agencies and individuals. The teams should provide support to local teams and publish an annual report that summarizes local case findings and provides recommendations for systemwide improvement in services to prevent fatal abuse and neglect.

Recommendation 13: Child Death Review Teams should be established at the local or regional level within states.

Local multidisciplinary/multiagency teams are the core of the child death review system. They conduct individual case review, assist with case management, and suggest followup and systems improvements. Regional teams may be effective in multicounty rural areas or in areas that border other nations. Such regional teams are also effective in key population centers and regions where counties may benefit from sharing information and statistics.

Recommendation 14: Model legislation should be enacted to address confidentiality.

Information sharing is critical to the effective functioning of Child Death Review Teams. Federal regulations should assure immunity from legal sanctions for agencies and team members who share information in the course of the team's work and protect such information from judicial discovery. States should enact legislation to clarify their ability to share information among law enforcement, CPS, mental health, and health agencies.

Recommendation 15: States and communities should assure that the religious community is included in efforts to prevent child abuse and neglect fatalities.

The religious community should be an active participant in State and local efforts to prevent serious and fatal child abuse and neglect. Members of the clergy should also be recognized as a vital resource in the provision of personal support, spiritual guidance, and counseling to surviving siblings and other family members who survive fatal child abuse and neglect.

Recommendation 16: All child and family programs must adopt child safety as a major priority.

Family, child welfare, health, mental health, and education programs must adopt children's safety as a major priority and explicitly assess the child's safety while providing services. Goals must also include the child's overall well-being and development and the preservation of the family.

Recommendation 17: All relevant State and Federal legislation must explicitly identify child safety as a goal.

Congress and State legislatures must explicitly identify child safety as a major goal. This goal must be statutorily presented as consistent with other public policy goals, such as family preservation and permanence for children.

Recommendation 18: The decision to remove children from their homes or initiate family preservation services should be made by a team.

Child protection and law enforcement agencies should use multidisciplinary team assessment and decision making whenever possible.

Recommendation 19: Family preservation services should be available in every jurisdiction.

Intensive family preservation services should be available in every jurisdiction as an option.

Recommendation 20: States should use guidelines when considering family preservation services.

Until the completion of needed research on the families most likely to be helped by family preservation services, States should use guidelines focusing on the safety and well-being of children in determining whether such services are the appropriate option for a specific family.

Recommendation 21: An array of primary prevention services and supports, including home visiting, must be made available to all families.

Primary prevention means helping families before an incident of abuse or neglect occurs. Because it is impossible to predict which families will kill their children, the most effective prevention is to support parents in being effective and nurturing, to provide treatment services when family problems do arise, and to respond quickly and appropriately when abuse or neglect is identified.

Recommendation 22: Family support services funding should be used for prevention programs aimed at families with infants and toddlers.

Because most children die from abuse or neglect before age 4, available Family Support funds and other prevention funds should be used to significantly increase the emphasis on mothers, fathers, and other caretakers of infants, toddlers, and preschoolers.

Recommendation 23: State and local agencies should design prevention programs for men. Programs should integrate services on child abuse and domestic violence and address the need for interagency training.

Specific strategies must reach men and alert women to the potential role of men in abuse. These strategies should be funded via Federal Family Preservation and Support monies, as well as public and private sources at the state and local levels. Because of the correlation and frequent coexistence of domestic violence and child abuse, programs must address all forms of family violence, especially when children are in the home.

Recommendation 24: Expedited TPR should be developed in every State.

When voluntary TPR is not an option, CPS agencies, States, and the juvenile courts should develop ways to expedite court TPR and placement with a permanent family in situations when a child cannot safely remain with or return to parental custody.

Recommendation 25: A broad public prevention campaign should be developed to address serious and fatal child abuse and neglect.

Well constructed campaigns can help educate parents about the triggers associated with serious injury and deaths of infants and children and suggest alternative means to cope with such problems. Such campaigns can also substantially increase public awareness about how to report abuse and how to prevent harm to children. The media should play a major role in this effort because of its unique ability to reach into homes of millions of people, including those who need help and those who might help others.

Recommendation 26: Regulatory measures should be adopted to reduce environmental dangers.

Regulations and codes should be enacted to end preventable child fatalities and serious injuries from household hazards and environmental dangers.

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